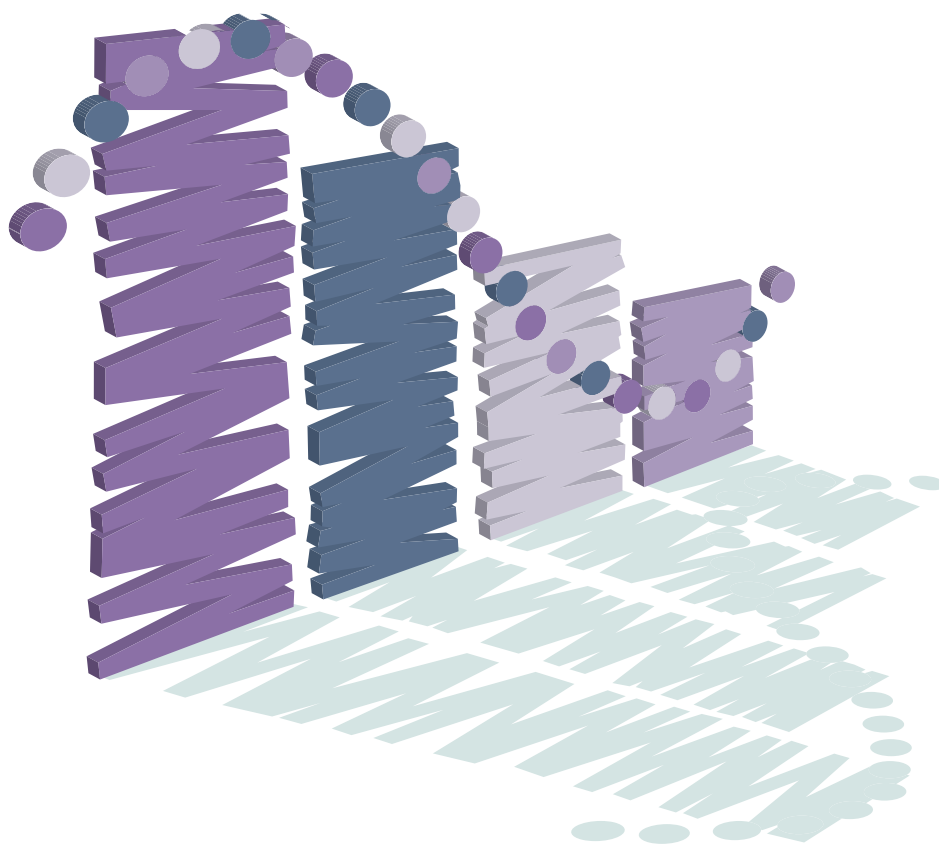


# Facility Questionnaire National Hospital Care Survey



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Centers for Disease Control and Prevention  
National Center for Health Statistics





# National Hospital Care Survey

## Part D: Facility Questionnaire

Thank you for participating in the National Hospital Care Survey. The information collected will be invaluable to hospitals, policymakers, researchers, and all who provide patient care in America's hospitals and health care systems.

If you have questions as you complete this form, please contact Ms. Carolyn Almen at 888-377-7161, extension 4744. Once this questionnaire is completed, please put it in the FedEx envelope provided and send it back to Westat, 1700 Research Blvd., ATTN: Debbie Brown, RB4148F, Rockville, MD 20850.

Notice - Public reporting burden for this collection of information is estimated to average 2 hours (already included in the 4 hour interview), including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0212).

Assurances of Confidentiality - All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

### 1. Hospital Information

(pre-printed label)

### 2. Person Completing This Form (If more than one person participated in completing this form, please record information for each person on next page):

Name:																								
Title:																								
E-mail:																								
Dept. Address:																								
Phone:				-				-				Fax:				-				-				

Additional people completing form:

Name:

Title:

E-mail:

Dept. Address:

Phone: 



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 Fax: 



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Name:

Title:

E-mail:

Dept. Address:

Phone: 



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Name:

Title:

E-mail:

Dept. Address:

Phone: 



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3. Is the information provided on this questionnaire only for the hospital named on the label on the previous page?

☐ Yes

☐ No → Please provide names of hospitals also included: \_\_\_\_\_

## Hospital Demographics

4. Please provide the hospital utilization statistics below for **calendar year 2010**.

If not for calendar year 2010, please indicate the 12 month period provided:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	TO	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH			YEAR					MONTH			YEAR			

a. Was this facility open as of 01/01/2010?

☐ Yes

☐ No → When did your hospital open?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DAY			MONTH			YEAR			

b. Total number of **acute inpatient** admissions:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
# ADMISSIONS			

c. Average length of stay (all acute inpatients):

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
# DAYS			

d. Total number of live births:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
# LIVE BIRTHS			

5. What is the ownership type of this hospital? *Mark (X) only one box.*

☐ Non-profit, not religious order affiliated

☐ Non-profit, religious order affiliated

☐ Government

☐ Proprietary

☐ Other → Please specify: \_\_\_\_\_

6. Is this a primary teaching hospital for a medical school?

☐ Yes

☐ No

7. Is this a critical access hospital?

☐ Yes

☐ No

## Health Information Technology

8. Does your hospital use electronic medical records (EMR) or electronic health records (EHR) system? Do not include billing record systems.

- ☐ Yes, all electronic
- ☐ Yes, part paper and part electronic
- ☐ No → skip to question 11
- ☐ Don't know → skip to question 11

9. In which year did you install your EMR/EHR system?

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YEAR

10. What is the name of your current EMR/EHR system?

Mark (X) only one box. If **Other** is marked, please specify the name.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allscripts     | <input type="checkbox"/> eMDs             | <input type="checkbox"/> Sage            |
| <input type="checkbox"/> Cerner         | <input type="checkbox"/> GE/Centricity    | <input type="checkbox"/> SOAPware        |
| <input type="checkbox"/> CHARTCARE      | <input type="checkbox"/> Greenway Medical | <input type="checkbox"/> Practice Fusion |
| <input type="checkbox"/> eClinicalWorks | <input type="checkbox"/> MED3000          | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Epic           | <input type="checkbox"/> NextGen          | <input type="checkbox"/> Unknown         |

11. Are there plans for installing a new EMR/EHR system within the next 18 months?

- ☐ Yes
- ☐ No
- ☐ Maybe
- ☐ Unknown

12. If orders for prescriptions or lab tests are submitted electronically, who submits them? Mark (X) all that apply.

- ☐ Prescribing practitioner
- ☐ Other
- ☐ Prescriptions and lab test orders not submitted electronically
- ☐ Unknown

13. Please indicate whether your hospital inpatient departments have each of the computerized capabilities listed below. *Mark (X) only one box per row.*

		Hospital Inpatient Wards			
Does the reporting location <u>have</u> a computerized system for:		Yes	Yes, but turned off or not used	No	Unknown
a.	Recording patient history and demographic information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a1.	<b>If yes</b> , does this include patient problem list?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Recording clinical notes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b1.	<b>If yes</b> , do they include a comprehensive list of the patient's medications and allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Ordering prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c1.	<b>If yes</b> , are prescriptions sent electronically to the pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c2.	<b>If yes</b> , are warnings of drug interactions or contraindications provided?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Providing reminders for guideline-based intervention or screening tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Ordering for lab tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e1.	<b>If yes</b> , are orders sent electronically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Providing standard order sets related to a particular condition or procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Viewing lab results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g1.	<b>If yes</b> , are results incorporated into EMR/EHR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Viewing imaging results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Viewing data on quality of care measures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Electronic reporting to immunization registries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Public health reporting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k1.	<b>If yes</b> , are notifiable diseases sent electronically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Providing patients with clinical summaries for each visit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	Exchanging secure messages with patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Can inpatient electronic medical records be accessed from the following hospital units?

Mark (X) only one box per row.

	Yes	No	Unknown
a. Intensive Care Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Emergency Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Observation Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Outpatient Departments:			
i. Emergency Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Outpatient Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Ambulatory Surgery Locations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Beginning in 2011, Medicare and Medicaid will offer incentives to hospitals that have demonstrated “meaningful use of health IT.” Are there plans to apply for Medicare or Medicaid incentive payments for meaningful use of health IT?

- ☐ Yes, we intend to apply
- ☐ Uncertain whether we will apply
- ☐ No, we will not apply

15a. In which year do you expect to apply for the meaningful use payments?

- ☐ 2011
- ☐ 2012
- ☐ After 2012
- ☐ Unknown

## Financial Information

16. What percent of your patient care revenue for **calendar year 2010** came from the following?

- a. Medicare \_\_\_\_\_ %
- b. Medicaid/CHIP \_\_\_\_\_ %
- c. Private insurance \_\_\_\_\_ %
- d. Patient payments \_\_\_\_\_ %
- e. Other (including charity, research, CHAMPUS, VA, etc.) \_\_\_\_\_ %

**TOTAL** 100 %

17. What percentage of your hospital’s revenue came from Medicaid and Medicare Disproportionate Share Program in 2010?

- a. Medicaid Disproportionate Share Program in 2010 \_\_\_\_\_ %
- b. Medicare Disproportionate Share Program in 2010 \_\_\_\_\_ %

## Outpatient and Emergency Departments and Special Hospital Units

18. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?

- ☐ Yes →
- ☐ No
- ☐ Don't know

18a. Number of beds

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# BEDS

19. Does this OPD include physician services?

- ☐ Yes
- ☐ No
- ☐ Don't know

20. Does this hospital have an Ambulatory Surgery Center (ASC)?

*ACS locations include a general or main operating room, dedicated ambulatory surgery room, satellite operating room, cystoscopy room, endoscopy room, cardiac catheterization lab, laser procedures room, and a pain block room.*

- ☐ Yes → 20a. Number of beds
- ☐ No
- ☐ Don't know

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# BEDS

21. Does your hospital have an Emergency Department?

- ☐ Yes →
- ☐ No
- ☐ Don't know

21a. Number of beds

--	--	--	--

# BEDS

21b. Is the Emergency Department staffed 24 hours per day?

- ☐ Yes
- ☐ No
- ☐ Don't know

22. Does this hospital have a dedicated Pediatric Emergency Services Area?

- ☐ Yes
- ☐ No
- ☐ Don't know



23. Does this hospital have a dedicated Psychiatric Emergency Services Area?

- ☐ Yes  
☐ No  
☐ Don't know

24. What is the trauma level rating of the Emergency Department and hospital?

Mark (X) only one box per row.

	None	Level I	Level II	Level III	Level IV	Level V	Other/ Unknown
a. Adult trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pediatric trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Does your hospital have a Neonatal Intensive Care Unit (NICU)?

- ☐ Yes  
☐ No  
☐ Don't know

26. What is the level of care provided by your NICU? Please mark (X) only one.

- ☐ I  
☐ II  
☐ III  
☐ IV  
☐ V  
☐ Don't know

27. Does your hospital have an Intensive Care Unit (ICU) other than the NICU?

- ☐ Yes  
☐ No  
☐ Don't know

28. Does your hospital have a dedicated observation unit?

- ☐ Yes → 28a. Number of beds

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# BEDS

- ☐ No  
☐ Don't know

## Staffing

We are also interested in finding out about ***hospitalists*** (physicians whose primary professional focus is the general medical care of hospitalized inpatients), excluding physicians who work in Intensive Care Unit(s).

29. Does your hospital employ ***hospitalists*** (*exclude physicians who work only in Intensive Care Units*)?

☐ Yes

☐ No

☐ Don't know

**Thank you for your participation!**

**Please return your completed facility questionnaire in the provided FedEx envelope.**